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An update from the Chronic Pain Guidelines Nov 2014

“Effective pain relief improves functioning whereas addiction decreases functionality”

Background:

* Nov 2011, CDC declares prescription drug abuse a nationwide epidemic
* **Drug overdose is now the leading cause of accidental deaths**, exceeding deaths due to MVA’s, the majority of which due to overdose involving prescription drugs
* Long term opioid therapy should ONLY be conducted in practice settings where careful evaluation, regular follow-up, and close supervision are ensured… deviations from these guidelines will occur and may be appropriate depending on unique individual needs… and physicians encouraged to document their rationale for each prescribing decision
* Guidelines are not meant to treat patients in hospice or palliative care

Definitions

* Acute vs. chronic pain (lasts longer than anticipated for usual course of condition, >3-6 mos)
* Nociceptive (tissue injury, “normal and physiological”) vs. neuropathic pain (abnormal neuronal firing, absence active tissue damage, hyperexcitability, complex) vs. compound pain
* Tolerance (diminution of drug effects with time), Dependence (withdrawal syndrome with cessation) and Addiction (1ary and chronic, neurobiological, multifactorial, impaired control, compulsivity, use despite harm to self)

Specific patient populations

* History of Substance use Disorder: using opioid risk tool, consult with specialist in addiction medicine, pain agreement, PDMP, Utox
* Psychiatric patients: “well defined somatic or neuropathic conditions”, seek appropriate specialist
* Co-prescribed benzos: encouraging benzo taper

Patient evaluation and risk stratification

* History, physical exam, Psychological eval (CAGE, PHQ-9, Opioid risk tool)
* Establishing a diagnosis with medical necessity
* A review of non opioid treatment options

Consultation needed?

* Knowing our limits and seeking help in co-management

Take home points:

1. Establishing boundaries early
2. Setting expectations at the onset when prescribing controlled substances
3. Developing “exit strategy” at the onset of prescribing controlled substances
4. Importance of documentation especially when deviating from the guidelines
5. Establishing one’s own boundaries to prescribing controlled substances and when to seek specialty care
6. Do we practice in a setting where “careful evaluation, regular follow-up, and close supervision” are ensured?

Source

Guidelines for Prescribing Controlled Substances for Pain. Medical Board of California. Nov 2014.http://www.mbc.ca.gov/licensees/prescribing/pain\_guidelines.pdf